Post-operative assessment: cataract and RLE surgery

Conlon Eye Institute
Medical Arts Building, 341-750 Spadina Crescent East, Saskatoon SK S7K 3H3
Phone (306) 244-4111 Fax (306) 244-9904 referrals@conloneyeinstitute.com
Monday to Friday, 7 am to 4 pm

Confidential. Personal health information. Follow-up visits vary by procedure. When the patient returns to your care, we send a surgery report and post-op guidelines.
RLE is usually done on both eyes the same day. Please complete both eyes when both were treated.

PATIENT AND THIS VISIT

Procedure (tick one): ☐ Cataract ☐ Refractive cataract ☐ Refractive lens exchange

Patient name: _____ Date of birth: _____ Chart or health number: _____

Eye(s) operated: ☐ OD ☐ OS ☐ Both Date of surgery: _____ Date of this exam: _____ Next appointment: _____

Lens type, if known (write in): _____

Visit interval: _____ days _____ weeks _____ months Other: _____

Typical visit (tick one). These are typical and may vary.

☐ 5 to 7 days ☐ 1 month ☐ 3 months ☐ 6 months ☐ 12 months ☐ Other _____

OD (right)

Complete for each eye examined.

UCVA 20/_____ UCNVA 20/_____ IOP _____ mmHg

Manifest refraction M _____ _____ x _____ 20/_____

BCVA 20/_____

Describe findings. Leave blank if not examined.

Cornea and incision: _____

Wound (including any leak): _____

Anterior chamber: _____

Intraocular lens position and clarity, if seen: _____

Other: _____

Medication: _____

Plan and comments: _____

OS (left)

Complete for each eye examined.

UCVA 20/_____ UCNVA 20/_____ IOP _____ mmHg

Manifest refraction M _____ _____ x _____ 20/_____

BCVA 20/_____

Describe findings. Leave blank if not examined.

Cornea and incision: _____

Wound (including any leak): _____

Anterior chamber: _____

Intraocular lens position and clarity, if seen: _____

Other: _____

Medication: _____

Plan and comments: _____

SEND BACK TO US RIGHT AWAY

Tick any that apply, then phone (306) 244-4111 and fax this form.

☐ Signs of infection after surgery (increasing pain, reduced vision or hypopyon)
☐ Wound leak
☐ IOP above 40
☐ Other concern, specify: _____

OPTOMETRIST

Name: _____ Billing number: _____ Clinic: _____

Phone: _____ Fax: _____ Email: _____ Signature: _____ Date: _____

Fax completed form to (306) 244-9904. Do not email patient information unless secure.